RECOMMENDED BEST PRACTICES – MEDICATION ERRORS

Best Practices adopted by Tennessee Improving Patient Safety (TIPS) on March 1, 2002

10 CONFUSING ABBREVIATIONS TO AVOID

The following chart shows medical abbreviations that often lead to unwanted outcomes:

Abbreviation	Intended Meaning	Common Errors
U	Units	Mistaken as a zero or a four (4) resulting in overdose. Also mistaken for "cc" (cubic centimeters) when poorly written.
ug	Micrograms	Mistaken for "mg" (milligrams) resulting in a ten-fold overdose.
Q.D.	Latin abbreviation for every day	The period after the "Q" has sometimes been mistaken for an "I," and the drug has been given "QID" (four times daily) rather than daily.
Q.O.D.	Latin abbreviation for every other day	Misinterpreted as "QD" (daily) or "QID" (four times daily). If the "O" is poorly written, it looks like a period or "I."
SC or SQ	Subcutaneous	Mistaken as "SL" (sublingual) when poorly written.
T I W	Three times a week	Misinterpreted as "three times a day" or "twice a week."
D/C	Discharge; also discontinue	Patient's medications have been prematurely discontinued when D/C, (intended to mean "discharge") was misinterpreted as "discontinue," because it was followed by a list of drugs.
HS	Half strength	Misinterpreted as the Latin abbreviation "HS" (hour of sleep).
cc	Cubic centimeters	Mistaken as "U" (units) when poorly written.
AU, AS, AD	Latin abbreviation for both ears; left ear; right ear	Misinterpreted as the Latin abbreviation "OU" (both eyes); "OS" (left eye); "OD" (right eye).

Resource:

Agency for Healthcare Research and Quality, ***http://www.ahrq.gov/consumer/20tips.htm***

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15 WAYS TO LOWER YOUR DOSE OF MEDICATION ERRORS

A study from the **University of Chicago Medical Center** places the incidence of medication errors between 1.7 and 59.1 percent. According to the **Joint Commission on Accreditation of Healthcare Organizations**, 15 percent of reported medication errors are due to confusion between drug names. Thousands more are due to confusing or misunderstood abbreviations.

According to the **Food and Drug Administration** and the authors of the **University of Chicago** study, the following guidelines can greatly reduce the number of medication errors:

1. Clearly write all orders with a ballpoint pen so that copies are legible.
2. Avoid the use of abbreviations and unnecessary symbols on drug orders.
3. Include the indication for the medication in each order, i.e. "for blood pressure."
4. Never guess about a medication order, but contact the physician if there are any questions about drug, dose, route, indication or instructions.
5. Avoid the use of verbal or telephone orders. When absolutely necessary, make sure the recipient repeats the order back to the physician.
6. Keep only necessary and authorized medications available to nursing staff and return other medications to pharmacy.
7. Always read the drug packaging label three times during the preparation of a dose.
8. Incorporate the "five rights" of drug administration into daily practice - right patient, right drug, right dose, right route, right time.
9. Try to avoid the use of a patient's own medication in a facility setting.
10. Never use trailing zeros when prescribing medications.
11. Always use a zero to precede a decimal point when prescribing less than one dose.
12. Physically separate dangerous medications and label them as such.
13. Keep the prescription and the label together and incorporate multiple checkpoints in the dispensing process.
14. Make the patient counseling session a final checkpoint in the drug dispensing process.
15. Provide brand and generic name on all medication labels.

Resource:
www.JCAHO.org

RECOMMENDED BEST PRACTICES – EFFECTIVE AND UNDERUSED SAFETY PRACTICES

Best Practices adopted by Tennessee Improving Patient Safety (TIPS) on March 1, 2002

The following 11 practices are the most highly rated of those in the **Agency for Healthcare Research and Quality's** report. The list is weighted toward clinical rather than organizational matters, and toward care of the very ill.

1. Appropriate use of prophylaxis to prevent venous thromboembolism in patients at risk.
2. Use of perioperative beta-blockers in appropriate patients to prevent perioperative morbidity and mortality.
3. Use of maximum sterile barriers while placing central intravenous catheters to prevent infections.
4. Appropriate use of antibiotic prophylaxis in surgical patients to prevent perioperative infections.
5. Asking that patients recall and restate what they have been told during the informed consent process.
6. Continuous aspiration of subglottic secretions to prevent ventilator-associated pneumonia.
7. Use of pressure-relieving bedding materials to prevent pressure ulcers.
8. Use of real-time ultrasound guidance during central line insertion to prevent complications.
9. Patient self-management for warfarin (Coumadin™) to achieve appropriate outpatient anticoagulation and prevent complications.
10. Appropriate provision of nutrition, with a particular emphasis on early enteral nutrition in critically ill and surgical patients.
11. Use of antibiotic-impregnated central venous catheters to prevent catheter-related infections.

Resource:
For 73 more best practices, go to www.ahrq.gov/clinic/ptsafety/spotlight.htm

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